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ABSTRACT

This study investigates prevention and treatment programs that deal with rural child sexual abuse in the State of Washington. A survey of 61 rural service providers examined agencies, services provided, problems faced in service delivery, and innovative solutions to those problems. The study compares responses from three types of agencies (mental health centers, child protective services, and sexual assault programs). Over 80% of all clinicians surveyed perceived a lack of trained counselors or resources to deal with the problem of child sexual abuse. Only 48% of those providing services thought child sexual abuse victims were receiving good services. The rating of problems by agency staffs showed a pattern of staff shortages, lack of resources, and increasing caseloads among all three types of rural agencies. Other problems included poor interagency coordination, lack of community support, and problems stemming from societal denial of sexual abuse. Agencies pointed to successes of community education programs on sexual abuse as a means of combatting denial of the problem. Coordination among existing services and agencies also appeared to be a successful approach. The report concludes that rural professionals dealing with child sexual abuse need additional resources and funding. This paper contains 32 references. (TES)

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Child Sexual Abuse Prevention and Treatment

Service Delivery Problems and Solutions

In Rural Areas

of Washington State

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Child Sexual Abuse Prevention and Treatment in Rural Areas

by JoAnn Ray, Ph.D. and Susan A. Murty, MSW

Abstract

Practitioners providing rural child sexual abuse prevention and treatment described their agencies, services provided, problems faced in service delivery, and their solutions to their problems.

Introduction

Child sexual abuse has been recognized in recent years as a serious problem which has been more prevalent than was previously believed. Child sexual abuse is traumatic, as evidenced by the reports and symptoms of adults who experienced sexual abuse as children (Finkelhor, 1984). In spite of greater national awareness and concern, however, the problem of child sexual abuse in rural areas has received relatively little attention. This paper reports on child sexual abuse prevention and treatment programs in rural Washington State. It identifies problems which service providers encounter in rural areas when they provide child sexual abuse prevention and treatment services. It reports on innovative approaches which have been effective in overcoming these problems.

Review of the Literature

A review of the literature indicates that child sexual abuse is a problem in rural areas and that the incidence is at least as high as in metropolitan areas (Committee on the Judiciary, 1985; Finkelhor, 1978; Halseth, 1982; Jens, 1982; Leistyna, 1980; Schultz & Jones, 1983). Reports on prevention and treatment programs to combat child sexual abuse in rural areas are limited and deal primarily with description of rural service delivery (Andrews & Linden, 1985; Deaton & Morgan, 1982; Halseth & Hein, 1982; Horner & O'Neill, 1981; Jens, 1982; Leistyna, 1980). The programs covered in these reports have encountered the problems associated with the delivery of other rural social services which have been documented. Some of these are community attitudes which are resistant to recognizing problems and accepting the value of social services (Jens, 1982; Sefcik & Ormsby, 1980; Halseth & Hein, 1982; Williams, 1982; Brown, 1980; Deaton &

Morgan, 1982; Kenkel, 1986; Alderette & deGraffenreid, 1985). Social isolation of many rural inhabitants contributes to social problems (Finkelhor, 1978; Halseth & Hein, 1982; Kenkel, 1986; Leistyna, 1980). People who are identified by the rural community as "deviant" may be especially isolated and may not have access to support systems (Stage & Gullerud, 1982; Kenkel, 1986). Limited resources and lack of professional staff to provide services are frequently cited as problems in rural areas (Andrews & Linden, 1985; Halseth & Hein, 1982; Bedics & Goltermann, 1981; Kenkel, 1986; Poole & Daley, 1985; Leistyna, 1980). Problems in protecting confidentiality are mentioned as particularly serious in rural areas (Jens, 1982). Distances to services and lack of public transportation create serious obstacles to receiving services (Sefcik & Ormsby, 1980). Rural communities are concerned about maintaining local control over programs (Johnson, 1980; Poole & Daley, 1985; McKenzie, 1982). Rural areas have higher rates of poverty and experience serious problems related to poor economic development (Leistyna, 1980; Kenkel, 1986; McKenzie, 1982; Halseth & Hein, 1982; Bedics, 1987; Coward, 1987; Fitchen, 1987; Jacobsen & Albertson, 1987). Problems of small town politics and "turfism" often interfere with rural social service programs (Sefcik & Ormsby, 1980). Confusion over responsibility and overlapping jurisdiction can prevent effective treatment and prosecution (Committee on the Judiciary, 1985). The isolation of rural practitioners from professional support and consultation is another problem typical of rural social service programs (Horner & O'Neill, 1981).

Particularly difficult problems are encountered in establishing prevention and treatment programs in rural areas to combat child sexual abuse. Denial and resistance in the rural community can be severe (Deaton & Morgan, 1982; Halseth & Hein, 1982; Jens, 1982). Children who experience sexual abuse are frequently not believed; in view of the strong denial in

rural communities, this may be even more of a problem in rural areas (Halseth & Hein, 1982). Locating rural focused prevention materials can be a challenge since most materials are written for urban children (Ray & Dietzel, 1985). Only a few materials written particularly for rural audiences have been published (Kleven, 1985, 1987). Problems identified with child sexual abuse service delivery include lack of coordination of services between agencies, and a large increase in cases resulting when prevention activities are initiated (Poole & Daley, 1985; Sefcik & Ormsby, 1980; Ray & Dietzel, 1985).

Practitioners who have established rural prevention and treatment programs to cope with child abuse and neglect report that a generalist approach is essential. Such programs include indirect services such as interagency collaboration and teamwork, community education and training, establishing links with formal and informal resources, and setting up volunteer and paraprofessional resources (Horner & O'Neill, 1981; Bedics & Goltermann, 1981; Andrews & Linden, 1985; Kenkel, 1986; Leistyna, 1980; Schechter, 1981). Programs which emphasize local community involvement and decision making have been recommended for rural areas (National Center for Child Abuse and Neglect, 1978; Northwest Indian Child Welfare Institute, 1984; McKenzie, 1982; Poole & Daley, 1985). Community education has been stressed as essential to effective rural programs responding to child abuse and neglect (Deaton & Morgan, 1982; Andrews & Linden, 1985). Indirect services cannot be provided alone, however. Direct services must be available to respond to the increase in demand for services that generally results from efforts to increase community awareness and improve interagency collaboration (Poole & Daley, 1985; Sefcik & Ormsby, 1980).

Methodology

An exploratory descriptive survey was completed using a mail-out questionnaire with follow-up telephone calls. Agencies in 30 rural and small town sites with a population of less than 25,000 and located further than a 50 mile radius from a city with over 50,000 were sampled in Washington State. Three types of agencies serving child sexual abuse victims were targeted: child protective service units, mental health centers, and sexual assault centers. The child protective service units are part of the state Department of Social and Health while the Mental Health centers are administered by each county. The network of sexual assault centers are locally funded and provide services to adult survivors of rape and to children who have experienced sexual abuse.

The questionnaire covered problems which might be encountered in rural areas and asked respondents to identify solutions which they had developed to overcome these problems. The problems listed included community resistance and denial, lack of expertise, lack of prevention materials oriented toward rural audiences, increased caseloads, difficulties maintaining confidentiality, long travel distances to services, and lack of coordination between agencies. Practitioners were asked to identify the type of treatment and prevention services they provided and the numbers of people served. In addition, information was gathered concerning the respondents themselves and the agencies where they worked.

Eighty questionnaires were mailed to the directors of the three types of agencies. A thank you reminder card was mailed a week later. After three weeks, the directors were contacted by telephone by research assistants. A total of 61 questionnaires were completed giving a return rate of 76.3%. The return rates for the three types of agencies were: Child Protective Service (19) 73.1%; mental health centers (27) 81.8%; and sexual assault agencies (15) 71.4%.

The data were analyzed with the SPSSX statistical package. A probability level of .05 or less was considered statistically significant. Content analysis was used to analyze the comments which were added by respondents concerning the problems and solutions.

Results

Characteristics of Agencies

The agencies were, as expected, small in size. The number of staff ranged from .1 to 20.5 full time equivalents (FTE). The median was 2.0 FTE. The mental health centers had more paid employees providing child sexual abuse prevention and treatment (mean 6.6 FTE) than the sexual assault agencies (mean 2.1 FTE) or child protective agencies (2.2). In the sexual assault agencies, on the other hand, volunteers played a more important role. All 15 of the sexual assault agencies in the survey reported using volunteers. The number of volunteers ranged from one to 40; the median was 8.5. In contrast, only three of the 27 mental health centers and one of the child protective service agencies reported using volunteers. On the average, the child protective service agencies and the mental health centers had been in operation longer (mean 14.9 years) than the sexual assault agencies (mean 6.5 years). All agencies provided services for other problems than child sexual abuse. Only 29.8% of the agencies had a separate unit which was developed especially to be responsible for the prevention and treatment of child sexual abuse.

Characteristics of Respondents

Most of the respondents who completed the questionnaire held the position of director or administrator of the agency; the second most common position was coordinator, followed by social worker, therapist, or

counselor. Twenty-seven of the respondents (44.3%) were in the 40 to 49 year old group. Approximately 60% were women, however, the mental health respondents were more apt to be male (59.3%) and the sexual assault center staff female (92.9%) (Chi square: $p = .0043$). Approximately one half respondents had grown up in relatively rural communities.

Clients Served

The mean number of clients served by all the agencies was 74.0. This number appears to be high considering the size of the agencies and the populations of the communities served. The data may be inaccurate due to the fact that one agency reported serving as many as 777 clients. On the average, for all the agencies surveyed, 26.5% of the clients served were child abuse clients. Nearly half (48.5%) of the clients served were residents of the more rural areas located outside the city or town in which the agency was located. Although staff of almost 90% of the agencies traveled to provide services, only 38% provided transportation to help clients reach locations where services were provided. The mental health center staff were less apt to provide transportation for their clients (8.0%) than did the sexual assault center staff (71.4%) or the child protective workers (61.1%) (Chi square: $p = .0001$).

Services Provided

An array of various child sexual abuse prevention and treatment services were offered by the rural agencies in the survey. The services provided most frequently by at least 75% of the agencies included direct services such as information and referral, and crisis intervention. As suggested in the literature, however, indirect services typical of generalist practice were also represented among the most frequent services: coordination with legal systems and medical systems, and training for

community citizens and for other professionals. Least frequently offered were therapy for perpetrators of child sexual abuse and group therapy for parents or children. Fifty percent of the responding agencies indicated that they referred perpetrators out of the community for therapy. Approximately one third of the respondents stated that they referred parents and children out of the community for group therapy, although almost 50% of the respondents stated that they were entirely or partially responsible for both these types of group therapy. Child sexual abuse prevention sessions were obviously a priority for the agencies in the survey. Three agencies reported more than 1000 prevention sessions in the last year.

The three types of agencies differed in their service delivery patterns. The mental health centers were more apt to provide treatment, including family therapy, child therapy, group therapy, and therapy for the perpetrators. The child protective services units provided the majority of the foster care. While the agencies shared the task of training professionals, the sexual assault centers held the major responsibility for providing community education and prevention programs for children. The percentages of agencies reporting that they were entirely or partially responsible for providing various services are presented in Table 1.

Insert Table 1 About Here

Perceptions of Service Delivery

The majority of the respondents (82%) agreed with the statement "There are not enough trained therapists and/or counselors in my community to deal with the identified sexual abuse cases." Nevertheless, 60% disagreed with the statement "Families with child sexual abuse problems are usually referred to a metropolitan area for therapy." Only just over one half

(54.3%) agreed with the statement "Child sexual abuse victims (survivors) are receiving good service in this community." Slightly more respondents disagreed (52.5%) than agreed (47.5%) that their community had a well coordinated network of agencies to deal with child sexual abuse treatment. A large majority of the respondents (76.3%) agreed with the statement "My agency sets a high priority on sexual abuse prevention and treatment."

Insert Table 2 About Here

The professionals from the three types of agencies differed considerably in their perceptions of the quality of the programs as shown in Table 2. The child protective service workers were considerably more apt to perceive that the clients were not receiving good services and that clients were referred out of the area for treatment services. The mental health workers, who provided most of the therapy, perceived the quality of the therapy somewhat higher than did the professionals in the other agencies. Similarly, the sexual assault center staff, who provided more child sexual abuse prevention services, perceived a better coordinated network of agencies to present prevention information.

Relationships to Other Agencies

The respondents were asked to plot a diagram to indicate how closely they worked together with other agencies and organizations to develop coordinated services and programs to address problems of child sexual abuse. If they worked most closely with an agency, they placed it in the inner circle. If they worked more peripherally with an agency, they placed it in a secondary circle. If they were not involved in working with an agency, they placed it in the outer circle. In the two inner circles, over 80% of the respondents placed the following agencies: child protective

services, mental health centers, police, and schools. Least likely to be included were the grange, clubs for children and adults, and church groups. Less than one fourth of the respondents indicated that they worked with these organizations. Figure 1 shows the overall pattern of working relationships with other agencies and organizations for the sample as a whole.

Insert Figure 1 About Here

The child protective service units appeared to be central to the service delivery system. The relationship between the sexual assault centers and the mental health centers appeared to be less central.

Differing patterns of involvement with other agencies were noted between the three agencies. Differences of 10% higher or lower than the mean of all agencies were analyzed. The child protective service workers more often reported a closer working relationship to hospitals, doctors, courts, and lawyers. The sexual assault centers more frequently reported closer relationships with the church, grange, and adult and children's clubs.

The agency relationship differences are no doubt related to the agency missions. The sexual assault agencies are frequently involved in providing preventive education for children and the community as a whole. In the course of carrying out these activities, it is logical to assume that they would become involved with community organizations such as clubs, granges, and church groups. The child protective workers have the responsibility of investigating reports of child abuse and screening and would therefore develop closer relationships with the legal and medical community. They or their agencies also license foster homes. The mental health centers have the primary focus of therapy and deal frequently with agencies over referrals, exchange of information, and case coordination.

Insert Figure 2, 3 & 4 About Here

Insert Table 3 About Here

Problems

Respondents were asked to rate between 1 and 10 the severity of a range of problems they might have encountered in providing services. The highest rated problems included lack of needed resources in the local area, increase in caseloads for the agency and for other agencies, shortage of staff, transportation, community denial of sexual abuse as a problem, and lack of needed expertise (means above 5.5). All agencies ranked problems with maintaining confidentiality and support from law enforcement as either minor or as no problem at all. See Table 4 for the order of problems as rated by the sample as a whole and by each agency type separately.

Insert Table 4 About Here

A comparison of the ratings of the problems by the three types of agencies to the means for all agencies provides some interesting information. The child protective service workers expressed a greater lack of support from law enforcement than the other two agencies. Child protective services must work closely with the police when documenting a child abuse case. The sexual assault centers experienced maintaining confidentiality as less of a problem, but viewed community denial as a more serious concern than the other agencies. Prevention is a major focus of the sexual assault centers, therefore community attitudes greatly effect their work. The child protective service workers and the sexual assault professionals noted a lack of expertise as a much more serious problem than did the mental health workers. The mental health workers, who were least

apt to transport clients, similarly viewed transportation as less of a problem than did the child protective workers or sexual assault staff.

Rural Problems and Solutions

The respondents were asked to add comments to the list of problems common in rural areas and to share their unique solutions. Their responses are summarized below:

1. Staff Shortage:

Shortage of staff was one of the most severe problems for rural practitioners. The low funding level was perhaps most seriously felt in limited staff. Low wages and burnout contributed to the problem. The need for female therapists and ethnic minority staff was also expressed.

Practitioners were dealing with the problem by using a combination of methods. Some were writing grants, others were utilizing volunteers or contract counselors. Sharing part-time help with other agencies or programs, using crime victim's compensation funds when possible, and piggy-backing on related grants, such as adolescent alcohol services were noted. Prioritizing cases by the severity of presenting problems and the degree of risk to the child was indicated as a solution by child protective service workers. Developing a sexual assault team utilizing staff from several agencies was also suggested.

2. Lack of Needed Resources for Families:

The list of needed services provided by the practitioners was long. Many agencies were unable to provide more specialized therapy such as working with the family as a whole, group therapy for children, parent therapy, and treatment for sexual offenders. Long waiting lists were common for existing services.

The list of solutions to these problems were, however, not as lengthy as the problems. The need for legislative changes and fund raising was noted.

3. Lack of Needed Expertise to Handle Cases:

The list of needed services, especially therapy, was reiterated under this problem. Waiting lists were mentioned. New staff members were being assigned cases before initial training was completed. Turnover of qualified staff was a problem due to heavy work load and low pay. Additionally, the need for training for staff and for other community professionals was indicated.

Workshops and training sessions were a common solution. Some practitioners from involved agencies in rural/small town communities were meeting together to form teams and to discuss approaches to this problem.

4. Increase in Caseloads for Own Agency:

Sexual abuse referrals have increased as much as 125% from the previous year according to the respondents. Large caseloads and waiting lists were common and agencies were unable to increase their personnel. Several practitioners stated they work harder, work overtime, or take work home.

Agency practitioners saw few solutions beyond additional funding. The agencies were applying for grants, and additional state support. Prioritizing cases and providing services to only the high risk children were suggested solutions.

5. Increase in Caseloads in Other Agencies:

Interestingly, the practitioners rated the increase in caseloads in other agencies as a more severe problem than they did their own caseload

increase. The over-load of cases for the Child Protective Workers was a frequent write-in comment by the sexual assault programs and mental health centers. The child protective service workers are concerned over the long waiting lists for therapy in the mental health centers.

Again the frustration of the practitioners was evident in their responses. The rural communities are attempting to coordinate their available resources as best as they can. Coordination may eliminate overlap in services, but unmet needs often require additional resources and improved coordination alone cannot provide them.

6. Poor Coordination of Services Between Agencies:

Not all communities were successful at coordinating services for child sexual abuse. Some agencies reported that "networking and coordination were excellent" and that they have "a close working relationship." Others commented that there were "turf problems," "agencies compete with each other," and "I work alone."

The development of multidisciplinary teams involved in case conferences and joint planning for services was a solution which proved to be successful for several communities.

7. Denial of Child Sexual Abuse:

The problem of denial was to be reported as more severe by sexual assault programs than the mental health centers or child protective workers. The practitioners commented that community denial showed up frequently in the lack of aggressive prosecution of cases in the community. A local case was found to increase the awareness of the community.

Community education was the most frequently mentioned approach for handling the problem of denial. Radio talk shows, public speaking, presentations in schools and churches, and newspaper articles were

mentioned. Providing a coordinated public education approach by the several agencies involved in child sexual abuse proved to be a successful approach for one community.

8. Religious Belief and Values:

The agency representatives stated that religious values emphasizing the importance of the family unit at all costs often increased difficulties intervening in child abuse situations. Religious leaders were seldom trained to work with abused families. A few respondents did not rate this problem and commented that they did not see how religious values could be considered a problem in relation to child sexual abuse.

Rural practitioners have found that working with and through the religious leaders achieved some success. The churches were a target for educational efforts and one sexual assault center included the religious leaders in their volunteer training.

9. Problem Maintaining Confidentiality for Victim and Family:

Maintaining confidentiality has historically been a rural service delivery problem, although this group of practitioners rated it among the less severe problems.

Agencies put emphasis on training and using consent forms. Breaks in confidentiality were dealt with by personnel action.

10. Problems Related to Transportation:

The lack of public transportation was noted by several rural/small town practitioners. Van services, grants for transportation services, and using volunteers to transport clients were solutions mentioned by staff.

11. Lack of Support of Local Officials:

The perception of the amount of support from local officials appeared to vary from community to community. Some perceived their officials as supportive, others as non-supportive.

A public education approach was most frequently suggested as a possible solution. Voting for candidates who are supportive of social service needs will help in the long run. In one community victims used picketing to increase awareness of local officials regarding plea bargaining.

12. Lack of Support From Law Enforcement:

This problem was perceived as one of the least severe for the practitioners. Several respondents noted that cooperation from law enforcement had improved over the past years. Improved support from law enforcement appeared to be related to joint training and joint planning.

13. Prevention Materials Appropriate for Rural Areas Not Available:

Most materials have been developed for urban areas and are not always appropriate for rural communities. This was especially noted as being a problem in rural areas with large minority populations.

Practitioners stated that they are adapting materials and that some materials were available through the state Child Protective Services and through the Coalition of Sexual Assault Programs.

Discussion

Agency Profiles

Separate profiles emerged for rural/small town agencies providing services to sexually abused children. The child protective workers had the

responsibility of investigating reports of child sexual abuse, they or their agencies licensed and supervised foster homes, and provided permanency planning for the children. The mental health centers were more involved in providing treatment for victims and their families. The sexual assault programs focused upon providing education to children, professionals, and the community.

In line with the differences in their missions the child protective services workers and the mental health workers networked more with the traditional agencies such as the schools, medical community, and the courts; in contrast the sexual assault programs were more frequently involved with community groups such as churches, granges, and clubs.

The sexual assault centers were younger than the other two agencies and were frequently smaller in staff. These sexual assault centers relied heavily upon volunteers to deliver their educational programs, while the other agencies were less able to utilize volunteers in therapy and treatment programs.

Identified Problems

Some patterns emerged from the ratings of problems by the agency staff serving sexually abused children. Lack of resources, staff shortages, and increase in caseloads were serious problems common to all types of agencies. Although family and child therapy was available in approximately three-fourths of the rural/small town communities, group therapy for parents and children was available only in approximately one-half of the communities. Therapy for the perpetrators was available in less than one-third of the rural/small towns. Waiting lists for services were common.

Community attitudes regarding sexual abuse often complicated the work of the professionals. Denial that abuse was happening in their community was frequently evidenced in the lack of aggressive prosecution. Religious

values that emphasize the importance of the family unit often made it difficult to adequately intervene in the family system.

Transportation is an ever-present problem in rural areas. Over one-half of the clients served in this study were from the rural areas surrounding the town where the agencies were located. Adequate access to the resources was a serious problem.

Interestingly, maintaining confidentiality, which is usually considered extremely difficult in rural/small town areas, was one of the least severe problems for these agencies. Perhaps, maintaining confidentiality was no less of a concern, however, it was over-shadowed by the severity of the problems related to lack of resources and staff.

Some problem areas were perceived as more serious by one agency type serving the sexually abused children. The child protective service workers and the sexual assault staff experienced the lack of needed expertise as a greater problem than the mental health practitioners. Consistent with their mission of education, the sexual assault center staff were apt to perceive community denial of child sexual abuse as a more severe problem. Caseload increases and difficulty maintaining confidentiality were greater concerns for the mental health program staff. The lack of transportation was perceived as a more severe problem by the child protective workers and the sexual assault centers staff who more often transport clients. Interestingly, while the relationships with the local law enforcement agencies were generally not perceived as a serious problem, the staff from the child protective service were apt to experience less cooperation from law enforcement officials.

Suggested Solutions

The practitioners offered suggestions for alleviating problems in service delivery to sexually abused children. Education regarding child

sexual abuse aimed at the community in general was the suggested solution to problems of community denial. This community education took the form of radio talk shows, newspaper articles, public speaking, and presentations to clubs and church groups. Training for religious leaders was a successful approach for dealing with religious values contradictory to child sexual abuse treatment and prevention. Local officials, too, were more supportive to the programs when they better understood the issues.

Indirect generalist activities such as training and coordination with the police, the medical community, and schools were reported as necessary for communities to provide comprehensive child abuse and treatment programs. Working with existing non-traditional organizations such as the church, grange, and clubs for adults and children, has been a successful approach for some agencies in providing education for the rural/small town communities. Less than one-fourth of all agencies, and only one-third of the sexual assault agencies, however, were working with these non-traditional agencies.

Coordination between existing services involving case management, shared planning, and service delivery appeared to be a successful approach to reduce the negative effects of limited staff, expertise, and services. Coordinating councils and intra-agency teams were noted as solutions by several agencies. While coordination can help expand limited resources by eliminating gaps and streamlining service delivery, the increase in caseload sizes faced by these agencies requires additional resources.

Conclusion

The need for additional resources and funding for professionals dealing with child sexual abuse is evident from this study. Over 80% of the clinicians perceived that there were not enough trained counselors to

deal with the problem. A surprising mere 48% of those providing services thought child sexual abuse victims were receiving good services. It is even more alarming to analyze this statistic by agency type. Only one out of five (21.1%) of the child protective service caseworkers perceived that their clients were receiving good services. Write-in comments helped to clarify this alarming statistic. Caseloads were increasing while staff was not increasing; in fact, staff was decreasing in some agencies. The workers were attempting to prioritize cases and work with the most serious risks. Child sexual abuse can never be considered anything but a serious risk. Many professionals worked overtime. Responses indicated that these practitioners were dedicated and were working hard to overcome severe obstacles with limited resources. But the morale of these workers who are protecting our children was low. They were concerned about the quality of services that they and the other professionals serving these children were providing.

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Table 1

Proportion of Agencies Reporting They Are Entirely or Partially Responsible for Providing Services

Services	Total Sample (%)	Child Protective Services Agencies (%)	Mental Health Centers (%)	Sexual Assault Centers (%)
Information and Referral	93.3	94.7	88.9	100.0
Crisis Intervention	91.5	100.0	85.2	92.9
Coordination With Legal	83.3	94.7	74.1	85.7
*1Training for the Community	79.7	84.2	66.7	100.0
Coordination With Medical	78.3	94.7	70.4	71.4
Training for Professionals	71.4	81.3	61.5	78.6
*2Family Therapy	64.9	20.0	96.3	53.3
*3Prevention Program for Child	59.3	56.3	44.0	92.3
*4Child Therapy	57.9	6.7	96.3	40.0
*5Foster Care	41.4	94.7	16.0	14.3
*6Group Therapy, Children	41.1	6.7	65.4	33.3
*7Group Therapy, Parents	36.8	6.7	51.9	40.0
*8Therapy for Perpetrators	23.2	0.0	38.5	20.0

1* Chi square p = .0413
2* Chi square p = .0000
3* Chi square p = .0205
4* Chi square p = .0000
5* Chi square p = .0000
6* Chi square p = .0009
7* Chi square p = .0139
8* Chi square p = .0182

Table 2

Perceptions of Service Delivery

Services	Total Sample (%) Agree	Child Protective Services Agencies (%) Agree	Mental Health Centers (%) Agree	Sexual Assault Centers (%) Agree
Treatment is Well Coordinated	47.5	36.8	59.3	40.0
Prevention Services are Well Coordinated	45.9	47.4	37.0	60.0
Not Enough Therapists in the Community	82.0	84.2	77.8	86.7
1 Families Referred to Metropolitan Area for Treatment	40.0	66.7	22.2	40.0
2 Sexual Abuse Victims Receive Good Services	47.5	21.1	68.0	46.7
Prevention Services are a High Priority	76.3	70.6	74.1	86.7

1* Chi square P = .0117
2* Chi square P = .0084

Table 3

Working Relationships With Other Agencies and Organizations Mapped as Closely or Peripherally Involved

Services	Total Sample (%)	Child Protective Services Agencies (%)	Mental Health Centers (%)	Sexual Assault Centers (%)
Child Protective Services	100.0	100.0	100.0	100.0
Mental Health Centers	96.7	100.0	100.0	86.7
Police	93.3	100.0	88.5	93.3
Schools	83.4	78.9	92.3	73.3
Doctors	77.6	94.8	80.8	46.2
Rape Crisis Center (Sexual Assault)	77.4	68.8	69.5	100.0
Public Health	76.2	78.9	84.6	57.1
Hospitals	74.1	84.3	76.0	57.1
Courts	71.4	84.2	72.0	50.0
Lawyers	55.2	68.4	50.0	46.2
Clergy	40.0	23.5	46.2	50.0
Adults' Clubs	20.0	12.5	15.4	38.5
Church	18.9	12.5	16.7	30.8
Childrens' Clubs	15.1	20.0	8.0	23.1
Grange	7.7	6.7	0.0	27.3

Table 4

Ratings of Problems by Agencies

Problem	Total Sample (%)	Child Protective Services Agencies (%)	Mental Health Centers (%)	Sexual Assault Centers (%)
Lack Resources	7.2	7.5	7.0	7.2
Other Agency Increase in Caseload	7.1	6.4	7.7	7.0
Staff Shortage	6.8	5.9	7.1	7.5
Own Agency Increase in Caseload	6.4	6.3	6.8	5.6
Transportation	6.1	7.4	5.1	6.2
Community Denial	5.9	6.0	5.1	7.3
Lack Expertise	5.9	7.0	4.9	6.3
Religious Beliefs and Values	5.4	4.9	5.3	5.9
Appropriate Prevention Material Not Available	5.2	5.5	5.0	5.0
Lack of Support of Local Officials	5.0	4.5	5.2	5.1
Poor Coordination Among Agencies	4.3	3.4	4.5	5.1
Maintain Confidentiality	3.2	3.9	3.3	2.0
Lack of Support From Law Enforcement	3.1	4.3	2.5	2.5

1 = No Problem
10 = Severe Problem

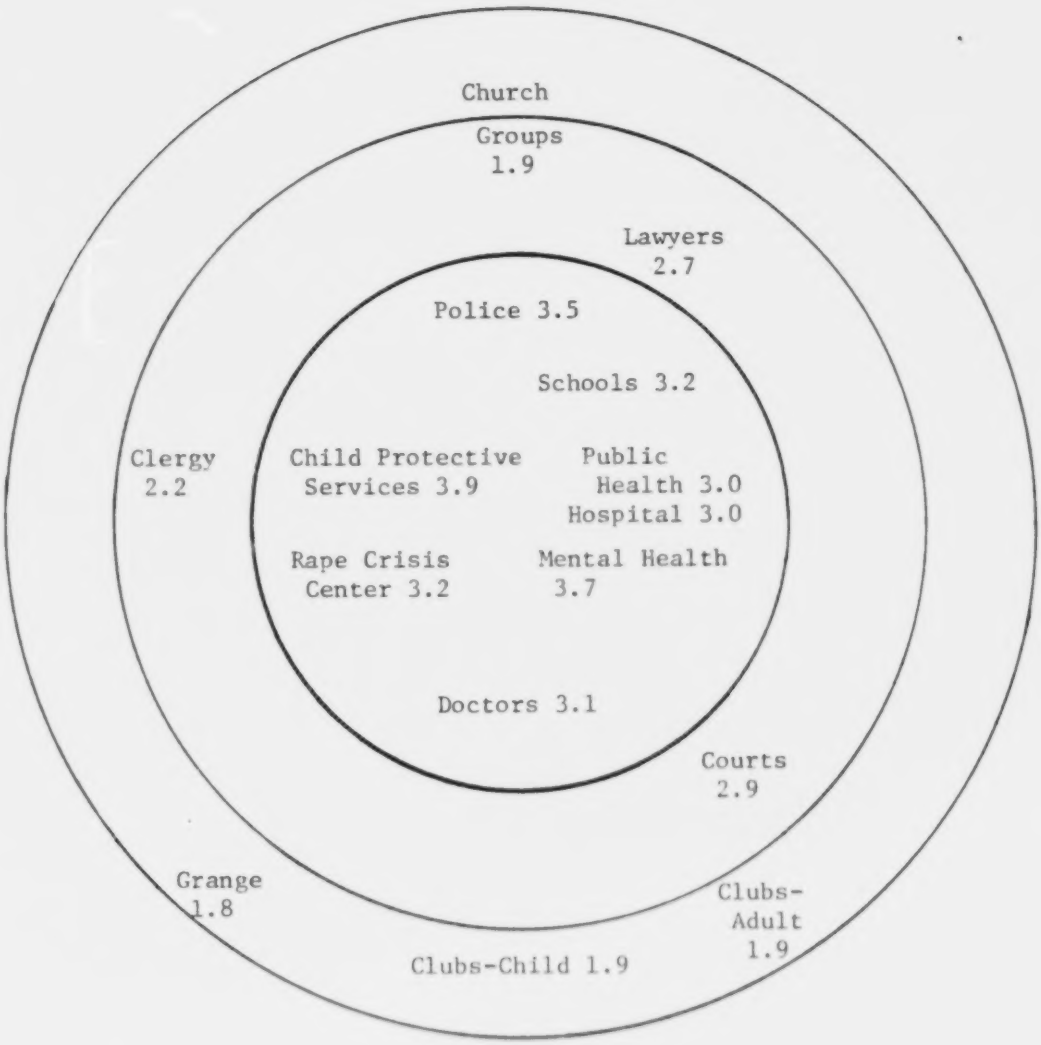

Figure 1: Total Sample
Working Relationships With Other Agencies and Organizations
To Develop Coordinated Programs and Services

Inner Circle: Work closely, mean 3.0-4.0
Middle Circle: Working relationship peripheral, mean 2.0-3.0
Outer Circle: Not involved, mean 1.0-2.0
Outside: Mean below 1.0

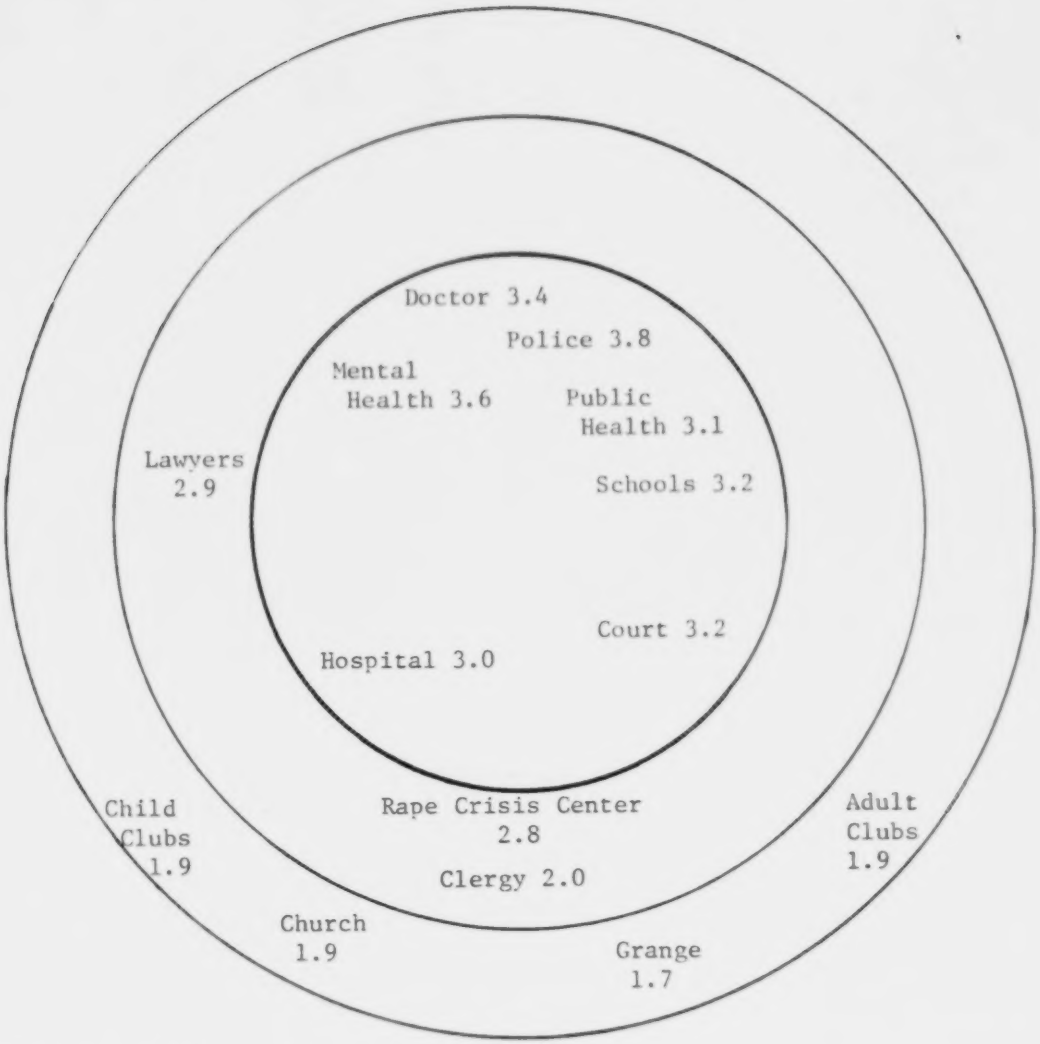

Figure 2: Child Protective Services

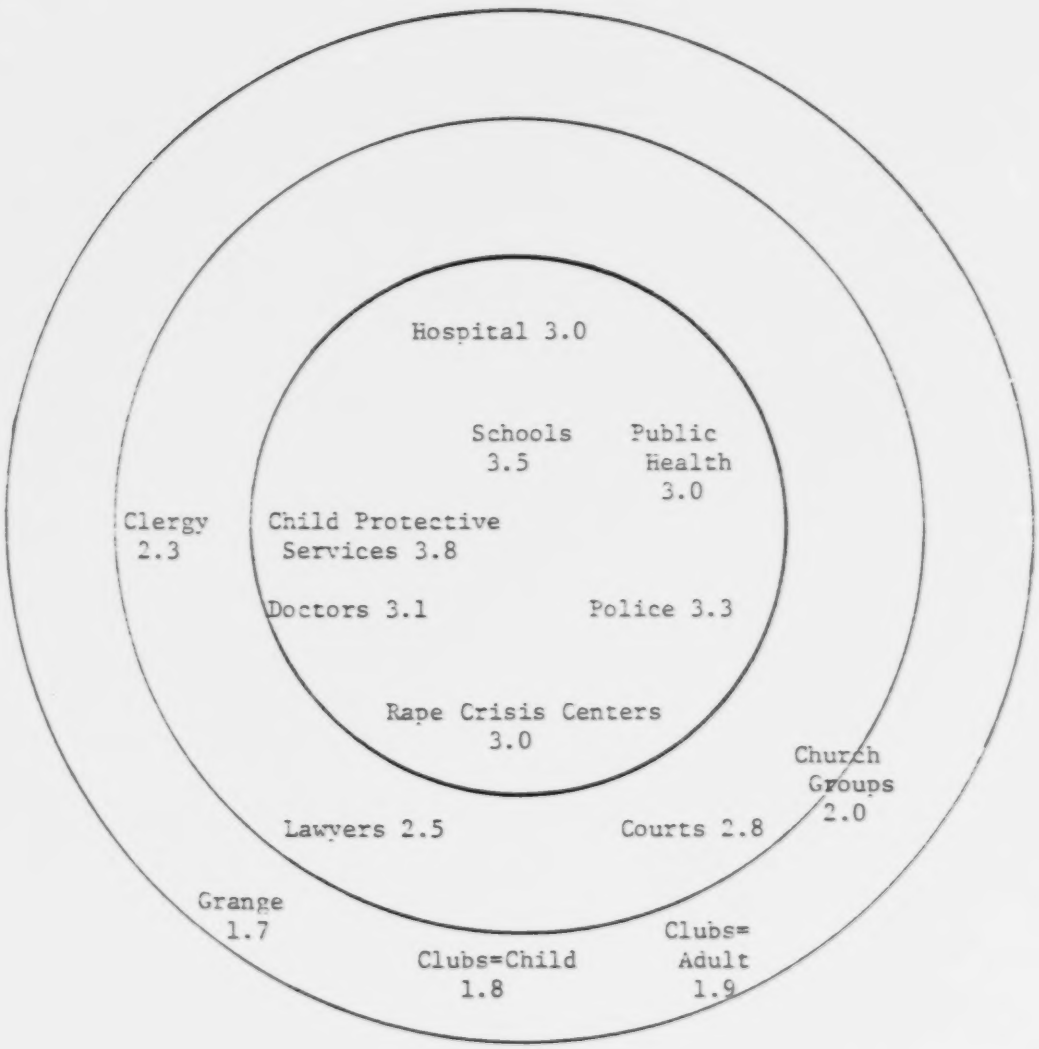

Figure 3 : Mental Health Centers

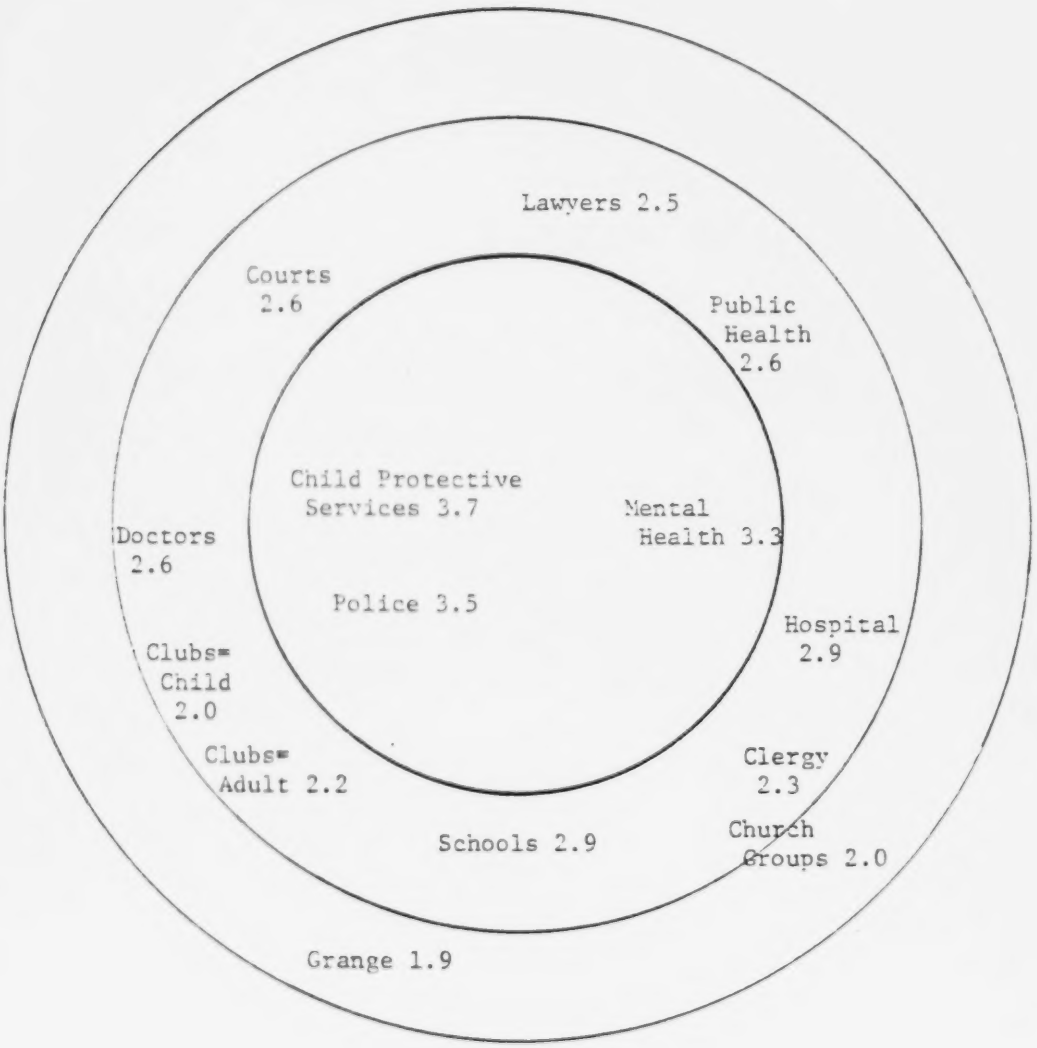

Figure 4: Sexual Assault Centers